



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG - Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

February 2, 2009

Vicki Salerno
Care At Home
501 North 16th Street, Suite 112
Payette, Idaho 83661

RECEIVED
FEB 12 2009
FACILITY STANDARDS

RE: Care At Home, provider #137068

Dear Ms. Salerno:

This is to advise you of the findings of the Medicare/Licensure survey at Care At Home which was concluded on January 23, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

Vicki Salerno
February 2, 2009
Page 2 of 2

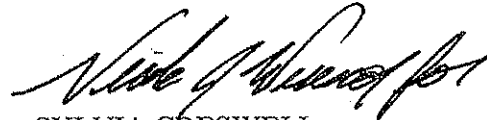
After you have completed your Plan of Correction, return the original to this office by **February 17, 2009**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,



PATRICIA O'HARA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PO/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your Home Health agency. The following surveyors conducted the Medicare recertification survey: Patricia O'Hara RN, HFS, Team Leader Teresa Hamblin RN, HFS Acronyms used in this report include: COPD - Chronic Obstructive Pulmonary Disease HHA - Home Health Agency LPN - Licensed Practical Nurse MD - Medical Doctor POC - Plan of Care PT - Physical Therapist or Physical Therapy RD - Registered Dietician RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care	G 000	RECEIVED FEB 12 2009 FACILITY STANDARDS On our initial assessment visit with the patient we present them with a consent to treat form which includes the payer source for this episode of care. We will add a sentence under the Medicare/Medicaid box that		
G 114	484.10(e)(1)(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay. This STANDARD is not met as evidenced by: Based on review of clinical records, agency forms and interview with HHA staff, it was determined the HHA failed to ensure 15 of 15 patients (#'s	G 114	lets the patient know that their expected liability for this episode of care is zero. Please see attached revised form. This form will be in use by March 1, 2009. It will replace the former consent form and will be permanently added to our start of care packet. Vicki Salerno, Administrator, will see that This form is replaced.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Vicki Salerno

Administrator

2.10.09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 114	<p>Continued From page 1</p> <p>1-15), whose records were reviewed, were informed in writing the extent to which payment could have been required from the patient. This had the potential to interfere with the patient's right to make informed decisions about whether to proceed with home care services. Findings include:</p> <p>Patient #1 was admitted to HHA services on 12/30/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #2 was admitted to HHA services on 1/16/09. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #3 was admitted to HHA services on 1/07/09. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #4 was admitted to HHA services on 7/14/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #5 was admitted to HHA services on 1/10/09. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #6 was admitted to HHA services on</p>	G 114			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 114	<p>Continued From page 2</p> <p>10/13/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #7 was admitted to HHA services on 12/11/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #8 was admitted to HHA services on 1/07/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #9 was admitted to HHA services on 12/23/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #10 was admitted to HHA services on 12/04/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #11 was admitted to HHA services on 11/13/07. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #12 was admitted to HHA services on 12/18/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment</p>	G 114			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 114	<p>Continued From page 3</p> <p>might have been required from the patient.</p> <p>Patient #13 was admitted to HHA services on 12/22/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #14 was admitted to HHA services on 12/16/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>Patient #15 was admitted to HHA services on 9/23/08. There was no documentation found in the clinical record to indicate the patient had been informed in writing of the extent to which payment might have been required from the patient.</p> <p>During an interview on 1/20/09 at 9:53 AM, the Director of Professional Services confirmed it was not the practice of the HHA to inform Medicare patients in writing of their expected financial responsibility or lack thereof. She stated it was the practice of the HHA to verbally inform patients when payment was not expected and to put in writing an expected percentage if a co-payment amount was anticipated. She explained that one of the initial forms provided to the patient listed the charges for the skilled visits. However, the forms did not inform the patient of the portion of the charges they would be expected to pay.</p> <p>A form titled "Care at Home Service Agreement," reviewed and revised March 14, 2008, informed patients that if their insurance denied payment, they would be personally and fully responsible for the payment. This form informed patients of</p>	G 114			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 114	Continued From page 4 general charges but not expected liability for charges.	G 114			
G 144	<p>The HHA failed to inform patients of the amount of the fees the patient might be expected to pay. 484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>This STANDARD is not met as evidenced by: Based on review of clinical records and interview with HHA staff, it was determined the HHA failed to ensure clinical records established effective reporting and coordination of care in 3 of 7 patients (#10, #14, and #1) who received more than one service and whose records were reviewed. This had the potential to interfere with continuity of patient care. Findings include:</p> <p>1. Patient #10, an 85 year old female whose SOC date was 12/04/08, received PT, SN, and bath aide services. HHA services related primarily to the patient's pneumonia and corresponding fatigue. A PT progress note, dated 12/08/08, indicated that the patient was started on a new medication. There was no documentation found as to the name or purpose of the new medication. There was also no documentation that the information regarding the new medication had been communicated to the RN. A PT progress note, dated 12/30/08, documented that the patient had started on another new medication, amitriptyline, 2 nights</p>	G 144	<p>The Director of Professional Services will review the medical Record for documentation of coordination of care among different disciplines. As each nursing/therapy progress note is submitted it will be reviewed for any new information regarding the patient that must be communicated to the physician or create documentation in the patient's medical record. For example, any new medications will be identified and added to the medication list. Also, there would be documentation that the MD was notified of changes in the condition of the patient. In therapy only cases the review of the progress notes will be performed by the therapy director. If the nutrition screen indicated necessary referral to the dietitian it would be given to the RD for follow up. The nutrition screen form will be revamped to add a place for the date and initials of the person when the referral is</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 144	<p>Continued From page 5</p> <p>prior. There was no documentation in the clinical record to indicate the medication sheet had been updated to include the new medication or that the information had been communicated to the RN. During an interview on 1/22/09 at 11:48 AM, the PT Director reviewed the chart and acknowledged that documentation was lacking. She stated it was likely the PT who saw the patient reported the information to her and that she, in turn, informally reported the information to the RN.</p> <p>2. Patient #14, a 67 year old male whose SOC date was 12/16/08, received SN services for care related to heart and lung conditions. LPN progress notes, dated 12/24/08 and 12/31/08, documented that the patient reported not using the inhaler medication as ordered for his lung condition. There was no documentation present in the clinical record stating the LPN had reported the medication non-compliance to the RN. During an interview on 1/23/09 at 12:51 PM, the Director of Professional Services reviewed the record and stated she believed the LPN had given an informal report to the RN but had not documented the coordination.</p> <p>3. Patient #1, a 23 year old quadriplegic male whose SOC date was 12/30/08, received SN services from the HHA for care related to bedsores. He also was received ongoing personal care services from a secondary agency.</p> <p>An undated form titled "Nutrition Screening Form" concluded the patient was at high nutritional risk and should be referred to a Registered Dietician (RD). The POC, dated 12/30/08, stated that the patient's rehabilitation potential was guarded due to the patient's lack of mobility and poor nutrition. There was no documentation that SN</p>	G 144	<p>given to the dietitian. Please see attached copy of the new form. This system will be in place by March 1, 2009. It will be monitored by Donna Forsyth, RN, DPS.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 144	Continued From page 6 communicated to the RD the need for a follow-up nutritional evaluation. During an interview on 1/20/09 at 3:30 PM, the RD/HHA Owner stated that the Nutrition Screening Form would have been completed on the opening date of 12/30/08. She stated that the referral should have come to her but that she had not seen the referral (21 days from the SOC date). During multiple interviews between 1/20/09 and 1/22/09, all staff (RN, RD/Owner and Aides) agreed that informal communication often occurred relating to Patient #1 but that communication was usually not documented. The HHA failed to ensure documentation of coordination of care.	G 144			
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on review of clinical records and interview with HHA staff, it was determined the HHA failed to ensure care followed a written plan of care established and periodically reviewed by a doctor in 3 of 15 patients (#6, #9, and #14) whose records were reviewed. This resulted in unreported medication non-compliance, unreported missed SN and bath aide visits, and bath aide services that did not follow the POC. Findings include: 1. Patient #14, a 67 year old male whose SOC date was 12/16/08, received SN services for care	G 158	We will make sure the aide has a copy of the plan of care in his or her possession before seeing a patient and/or they will sign the plan of care in the home to ensure they have read and reviewed it. When the RN or PT do supervising bath aide visits they will check for the care plan and bath aide signature in the home. The DPS and/or Therapy Director will review the bath aide Progress notes as they are submitted. Each patient receiving bath aide services will be identified to the scanner operator who will give the progress notes to the DPS/Therapy Director for review. The progress note will be initialed to indicate this review.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 158	<p>Continued From page 7</p> <p>related to heart and lung conditions. The POC, dated 12/16/08, included orders to assess for medication compliance. LPN progress notes, dated 12/24/08 and 12/31/08, documented the patient reported not using his inhaler medication as ordered for his lung condition. There was no documentation present in the clinical record that the medication non-compliance had been reported to the physician. During an interview on 1/23/09 beginning at 12:51 PM, the Director of Professional Services reviewed the record and confirmed there was no documentation to suggest the medication non-compliance had been reported to the physician.</p> <p>The POC, dated 12/16/08, also included orders for bath aide services. Bath aide notes, dated 12/18/08 through 1/09/09, did not indicate that bath services were being providing according to the nursing plan of care. During an interview on 1/23/09 at 12:51 PM, the Director of Professional Services reviewed the record and stated that the patient had refused bath aide services. She confirmed there was no documentation to suggest the physician had been informed of the patient's refusal to accept help with a bath. She explained that the reason bath aide progress notes were in the record was because he was receiving personal care services through another company and the notes had been misfiled in the skilled chart.</p> <p>The HHA failed to notify the physician of medication non-compliance and refusal of the patient to accept bath aide services.</p> <p>2. Patient #9 was a 77 year old female admitted for HHA services on 12/23/08. Diagnoses included COPD and pneumonia. Her POC, dated</p>	G 158	<p>In the case of medication non-compliance or other non-compliance to the plan of care, the MD will be notified by the visiting nurse immediately by phone, and if MD is not reachable the nurse will call the agency and notify the DPS who will follow up with another phone call and/or written notice. In both of these cases there will be documentation in the medical record to verify this was done. It is the responsibility of the DPS to review all nursing progress notes as they are submitted. Each progress note will be initialed by DPS to verify review.</p> <p>In the case of missed visits by the nurse, therapist or bath aide, the missed visit note will be faxed to the physician. To verify that this has been done, the missed visit note will be attached to the printed fax completion form. The missed visit note will not be filed in the patient's medical record unless attached to the printed fax completion form. It will be the responsibility of the medical records specialist to only file missed visit notes with the printed fax completion form attached. If this is missing, the form will be refaxed.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 158	<p>Continued From page 8</p> <p>12/23/08, included bath aide services two times a week for weeks two, three and four of the certification period. Aide visits were made on 1/19 and 1/22/09, during week five, without MD orders.</p> <p>An Aide Care Plan, undated and signed by the RN, found in the patient's record, instructed the aide to take the patient's temperature, pulse, respirations, blood pressure and weight at each visit. During a home visit by the surveyor on 1/22/09, the aide was asked if these vitals signs were being done. She stated that she had not seen the Care Plan before this date and that vital signs had not been done with each visit. She stated, "they just called me and told me to come and give her a bath." A copy of the Aide Care Plan was present in the home.</p> <p>In an interview, on 1/22/09 at 2:00 PM, the Director of Professional Services confirmed that extra visits had been made without MD orders. She also stated she was unaware that aides were not following the Aide Care Plan.</p> <p>Visits were not made according to the POC and the POC was not followed by staff members.</p> <p>3. Patient #6 was a 79 year old female admitted on 10/13/08 for SN monitoring and teaching related to uncontrolled diabetes. The patient's POC, undated, called for SN visits twice a week for one week, then once a week for three weeks, then every other week for five weeks. Review of the patient's record showed the patient had refused a SN visit on 10/27/08. A missed visit report indicated this was the patient's decision. Subsequently, the patient did not have SN supervision for 20 days. The MD was not notified</p>	G 158	<p>This system will be in place by March 31, 2009, following inservice of all nursing, therapy and medical records staff.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 158	Continued From page 9 of this missed visit.	G 158			
G 159	<p>During an interview on 1/22/09 at 1:00 PM, the Director of Professional Services stated that the agency policy was to fax the missed visit form to the MD, attach the fax verification form and file both in the patient's clinical record. Further, she confirmed that the MD was not made aware of the missed visit.</p> <p>The MD was not notified that the POC had not been followed.</p> <p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on review of clinical records and interview with HHA staff, it was determined the HHA failed to ensure a POC was developed to cover pertinent safety measures to protect against injury in 1 of 15 patients (#1) whose records were reviewed. This had the potential to result in patient harm and inadequate coordination of care. Findings include:</p> <p>Patient #1 was a 23 year old quadriplegic male whose SOC date was 12/30/08. He was referred to the HHA for care related to bedsores. He lived</p>	G 159	<p>The DPS conducted an inservice with the assessing RN's, the therapy director, and staff therapists on February 4, 2009, to review the completion of the OASIS as it pertains to each patient's overall condition and safety issues. They were reminded to sign and date the nutrition and safety screening forms and to include relevant findings in the POC. Documentation of attendance at this review will be included in personnel files.</p> <p>Attempts to ensure the safety of our patients will include coordination with other disciplines like therapy and social work as well as calls to outside agencies such as adult protection, health and welfare and case management as appropriate. Documentation of coordination with outside agencies also caring for a patient will always be included in the medical record.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 159	Continued From page 10 alone, having moved from his mother's home to an apartment the previous month. Personal care attendant services provided care 5 hours per day from 10:00 AM to 1 PM and again from 7:30 PM to 9:30 PM. This schedule left him potentially alone for up to 19 hours per 24-hour period. An undated Safety Review assessment indicated the patient was bed bound, wheelchair bound, frail, fragile, and left alone. The POC, dated 12/30/08, addressed the need for SN to attend to wounds and cardiopulmonary status. It did not address identified safety issues related to his living alone and bed bound status. During a home visit on 1/21/09 between 10:15 AM and 11:15 AM, the nurse and aide were observed providing care for the patient who remained verbally and physically unresponsive throughout care. The patient's eyes were closed and he did not respond to questions. During an interview at the time of the home visit, the LPN stated she thought the patient needed 24 hour care and would benefit from social work intervention. During a second home visit on 1/22/09 at approximately 1:30 PM, the patient was awake, dressed, sitting in a wheelchair and able to demonstrate use of his cell phone and respond appropriately to questions. The patient confirmed he spent many hours alone and stated he could use the phone to call for help. During an interview on 1/22/09 beginning at 9:10 AM, the Director of Professional Services and RD/HHA Owner explained that a formal POC was not developed for safety issues because it was their understanding that the POC was supposed to be limited to the reason for the referral, which in this case was for wound care. They further explained that they too were concerned about the patient's safety and had engaged in many informal, undocumented conversations with Case Managers from outside agencies to discuss the	G 159	This will be our ongoing practice starting immediately. DPS and Therapy Director review all medical records monthly in preparation for report to our Medical Director and our interdisciplinary team during care conference. These issues will be reviewed with all licensed staff during inservice before March 31, 2009.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 159	Continued From page 11 patient's needs. They confirmed that a POC for the patient's safety needs was not formally developed.	G 159			
G 236	The HHA failed to ensure a POC was developed for relevant safety issues. 484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on review of clinical records and interview with HHA staff, it was determined the HHA failed to ensure specific clinical notes were signed and dated in 1 of 15 patients (#1) whose records were reviewed. This resulted in a lack of clarity as to when a safety assessment and a nutritional screening were completed and therefore when interventions should have been initiated. Findings include: Patient #1 was a 23 year old male whose SOC date was 12/30/08. The clinical record contained an undated but completed "Nutrition Screening Form" and an unsigned, undated, but completed "Safety Review" form. During an interview on 1/20/09 at 2:19 PM, the RD/HHA Owner acknowledged the forms were undated/unsigned	G 236	DPS conducted an inservice with assessing RN's, Therapy Director and staff therapist on February 4, 2009, to review the completion of the start of care packet and were reminded to sign and date all forms. Documentation of attendance at this review will be included in personnel files. Another inservice will be conducted for licensed staff before March 31, 2009. When the start of care packets are submitted from the assessing professional they will be reviewed for dates and signatures by the DPS or Therapy Director. If any omission is found, it will be returned to the assessing professional for completion.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 236	Continued From page 12 and stated that they would have been completed on the SOC date of 12/30/08.	G 236			
G 337	<p>The HHA failed to ensure the clinical record was maintained according to accepted professional standards to include dates and signatures.</p> <p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>This STANDARD is not met as evidenced by: Based on review of clinical records and interview with HHA staff, it was determined the HHA <u>failed</u> to ensure a comprehensive drug review in 1 of 15 patients (#1) whose records were reviewed. This resulted in a patient not being fully assessed as to the reasons for not taking medication. Failure to assess the reasons for noncompliance and alert the physician to the noncompliance affected the physician's ability to alter the plan of care. Findings include:</p> <p>Patient #1 was a 23 year old quadriplegic male whose SOC date was 12/30/08. On an initial RN assessment form, dated 12/30/08, documentation indicated the patient was non-compliant with drug therapy. There was no documentation to indicate if the patient was non-compliant with all medications or a specific medication. There was also no indication SN assessed the patient's reasons for noncompliance. During a home visit on 1/22/09 at 1:30 PM, the client reported that he did not take all of his medications because they</p>	G 337	Please see G158		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 337	Continued From page 13 made him tired and they did not seem to work. The HHA failed to comprehensively assess and report a patient's non-compliance with drug therapy.	G 337			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your Home Health agency. The following surveyors conducted the Medicare recertification survey: Patricia O'Hara RN, HFS, Team Leader Teresa Hamblin RN, HFS	N 000		
N 041	03.07020. ADMIN. GOV. BODY N041 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: c) The charges that the patient may have to pay; and This Rule is not met as evidenced by: Please refer to Federal tag #114 as it relates to the agency's failure to inform patients about possible financial liability for services.	N 041	Please see G114	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange,	N 062	Please see G144	

RECEIVED
FEB 12 2009
FACILITY STANDARDS

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

1FU111

If continuation sheet 1 of 5

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 062	Continued From page 1 reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Please refer to Federal tag G144 as it relates to the agency's failure to establish that coordination of care occurred between disciplines providing care to patients.	N 062			
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Please refer to Federal tag G158 as it relates to the agency's failure to 1) ensure staff provided care following the patient's POC and 2) notify the MD that the POC was not followed.	N 152	Please see G158		
N 162	03.07030.PLAN OF CARE N162 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: j. Any safety measures to protect against injury;	N 162	Please see G159		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 162	Continued From page 2 This Rule is not met as evidenced by: Please refer to Federal tag G159 as it relates to the agency's failure to ensure that patients' POC's addressed all identified problems.	N 162			
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Please refer to Federal tag G337 as it relates to the agency's failure to ensure that patients medication non-compliance was assessed.	N 173	Please see G158		
N 180	03.07031.CLINICAL REC. N180 02. Contents. Clinical records must include: f. Signed and dated clinical and progress notes; This Rule is not met as evidenced by: Please refer to Federal tag G236 as it relates to the agency's failure to ensure clinical and progress notes were signed and dated.	N 180	Please see G236		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 186	<p>03.07031.03.CLINICAL REC.</p> <p>N186 03. Clinical and Progress Notes, and Summaries of Care. Clinical and progress notes must be written or dictated on the day service is rendered and incorporated into the clinical record within seven (7) days. Summaries of care reports must be submitted to the attending physician at least every sixty (60) days.</p> <p>This Rule is not met as evidenced by: Based on review of clinical records and interview with HHA staff, it was determined the HHA failed to ensure clinical and progress notes were written and incorporated into the clinical record within 7 days in 2 of 15 patients (#13, #9) whose records were reviewed. This had the potential to interfere with clarity as to what services were actually provided, the condition of the patient at the time of service, and coordination of patient care. Findings include:</p> <p>1. Patient #13 was a 77 year old female whose SOC date was 12/22/08. The POC, dated 12/22/08, called for PT visits 2x per week for 7 weeks after the first week. During week 3, there was documentation that only one PT visit was made, on 1/07/09. There was no documentation found to suggest a second PT visit had been made during week 3. During an interview on 1/22/09 at 3:28 PM, a PT stated that she believed a second visit had been made during the week but that the PT progress notes had not yet been turned in, 13 days after the visit.</p> <p>2. Patient # 9 was a 77 year old female admitted on 12/23/08 with diagnoses including COPD and pneumonia. The patient's POC, dated 12/22/08, included orders for PT to visit the patient twice a</p>	N 186	<p>For licensed staff in outlying areas, stamped addressed envelopes will be provided for progress notes to be submitted within 24 hours of completion of patient visit.</p> <p>We will also provide pick up courier service as needed for progress notes.</p> <p>Once received in the agency, the progress notes will be reviewed, expeditiously scanned and filed in the patient's medical record within 7 days. For any delayed progress notes, the clinician will be contacted by telephone by the DPS or Therapy Director. The Medical Records Specialist will be responsible for filing the progress notes in the medical record within 7 days.</p> <p>All licensed staff will be inserviced by March 31st, 2009, regarding this plan.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2009
NAME OF PROVIDER OR SUPPLIER CARE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 16TH STREET SUITE 112 PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 186	<p>Continued From page 4</p> <p>week for one week, then four times a week for one week, then three times a week for five weeks. A review of the patient's chart on 1/22/09 showed no PT visit notes for 1/2 - 1/14/09, for a total of five visits.</p> <p>In an interview on 1/22/09 at 1:00 PM, the Director of Professional Services stated the missing visit notes were located in a file of papers waiting to be scanned and placed in the patient's chart.</p> <p>The agency failed to ensure that clinical notes were placed in the patient's chart within seven days.</p>	N 186			